A Compelling Call to Action to Establish a Culture of Respect

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Humble, gracious, polite, courteous, civil, considerate, well-mannered. If these words do not describe the interactions between health care professionals at your hospital, you are, sadly, not alone. Bullying, incivility, and other forms of disrespectful behavior are rampant in health care, allowed to exist while we tolerate the behavior, remain silent, or make excuses—"That's just the way he is"—in an attempt to minimize the profound and far-reaching devastation that disrespectful behavior causes.

While a culture of disrespect is harmful on many levels, its effect on patient safety makes it a matter of national urgency, according to Lucian Leape, MD, of the Harvard School of Public Health and his esteemed colleagues, who authored a two-part exploration of disrespectful physician behavior in the journal *Academic Medicine*.[1–2] Although disrespectful behavior is not limited to physicians, they often dominate the culture and set the tone—thus the authors' focus on physician behavior. What follows is a brief overview of the compelling call to action to create a culture of respect in health care from Dr. Leape and colleagues.[1–2]

According to the authors, the widespread disrespect that persists unchecked in health care is a substantial barrier to our progress in patient safety. In Part 1 of their two-part series, the authors suggest that our slow progress in this area is due not to lack of resources or know-how but to a dysfunctional culture, central to which is a physician ethos that favors privilege and autonomy.[1] A sense of privilege and status can lead physicians to treat nurses and other health care professionals with disrespect, impairing teamwork and communication. Disrespect causes the recipient to experience fear, anger, shame, confusion, uncertainty, isolation, self-doubt, and depression. The authors note that these feelings diminish a person's ability to think clearly, make sound judgments, speak up regarding questions, and resist engaging in at-risk behaviors. The authors further suggest that a sense of physician autonomy can underlie a resistance to collaborate with others, follow procedures that promote safe practices, or implement new safety practices.

Dr. Leape and colleagues point out that students and patients also experience the consequences of disrespectful physician behavior. Students and residents suffer from the traditional medical "education by humiliation," lessening their willingness to speak up about hazards and errors and perpetuating the disrespectful behavior when they later mimic the learned behavior. Patients suffer from dismissive treatment by physicians who do not listen, show disdain for questions, or fail to explain alternatives. The authors remark that the physician's failure to provide full and honest disclosure to patients when things go wrong is the epitome of disrespect.

The authors identified a broad range of disrespectful conduct, from aggressive outbursts to subtle patterns of disrespectful behavior so embedded in our culture that they seem normal. They classify the behaviors into six categories:

Disruptive behavior is egregious conduct such as angry outbursts, verbal threats, demeaning comments, swearing, throwing or breaking objects, bullying, shaming and censuring staff in front of others, insensitive jokes or remarks, and the threat or infliction of physical force or contact.

Humiliating or demeaning treatment involves patterns of behavior, more common than isolated egregious behavior, the authors say, ranging from ongoing humiliation and exploitation to simply ignoring others. Repetitive demeaning treatment of nurses, medical students, and residents has resulted in numerous cases of "burnout" and clinical depression in an environment where such behavior is tolerated or even celebrated.

Passive-aggressive behavior includes negativistic attitudes and passive resistance to demands for adequate performance. These individuals are unreasonably critical of authority and make negative comments about colleagues. They refuse to do tasks, deliberately delay responding to calls, and go out of their way to make others look bad while acting innocent.

Passive disrespect involves uncooperative behaviors that are not malevolent. These individuals are chronically late to meetings, respond sluggishly to requests, and do not work collaboratively with others. They resist safe practices such as time-outs and decline to participate in improvement efforts.

Dismissive treatment of patients is condescending behavior that makes patients feel unimportant and uninformed, which can be particularly devastating to an apprehensive patient. Dr. Leape and colleagues note that some physicians treat nurses, students, residents, and even peers in the same manner, making collaboration impossible.

Systemic disrespect involves behaviors so entrenched in patient care that the element of disrespect may be overlooked. Making patients wait for services is one example, implying that the physician's time is more important than the patient's. Long hours, sleep deprivation, and excessive workloads are also examples of systemic disrespect for both staff and patient well-being.

Dr. Leape and colleagues suggest that disrespectful behavior results in part from the endogenous characteristics of the individual, such as insecurity, anxiety, depression, aggressiveness, and narcissism, which serve as a form of self-protection against feelings of inadequacy. However, the authors make it clear that disruptive behaviors are also learned, tolerated, and reinforced in both the health care culture and the societal culture at large, where civility is regarded as an invitation to exploitation and where a

certain degree of disrespect is considered a normal style of communication. Nevertheless, the authors are quick to point out that the major exogenous factor leading to disrespectful behavior is the stressful environment of health care, particularly in academic environments and in the presence of "production pressure," such as being required to see a high volume of patients.

In Part 2 of their series, Dr. Leape and colleagues emphasize that eliminating disrespectful behavior requires cultural transformation to establish a supportive and nurturing environment with high levels of mutual trust, interpersonal responsibility, person-centeredness, supportiveness for coworkers, civility, friendliness, and creativity.[2] The authors suggest that a culture of respect is a "precondition" to make health care safe.

While transformation should begin in the medical schools, where professional respect should be practiced by working in teams with nurses and pharmacists, Dr. Leape and colleagues stress that responsibility for addressing the problem in the clinical setting belongs to organizational leaders, who need to:

1. Raise awareness of the problem, motivate and inspire others to change, communicate respect as a core value, articulate his or her commitment to achieving this value, and create a sense of urgency around doing so.
2. Establish preconditions for a culture of respect by assessing and revising policies that affect hours and workloads for all workers and mitigation of physical hazards (e.g., needlesticks and back injuries).
3. Lead the establishment of a code of conduct for everyone that calls for mutual respect regardless of rank or status and that outlines a detailed process for managing disruptive behaviors.
4. Facilitate engagement of front-line workers by addressing systemic issues such as environmental stressors that cause and promote disrespectful behavior.
5. Create a learning environment where students, who learn by emulating their teachers, are mentored with mutual respect and nontolerance for abusive behaviors.

Dr. Leape and colleagues highlight the characteristics of an effective code of conduct, including fairness to all parties, consistency in enforcement, a graded response to infractions determined by seriousness and frequency, a restorative process to help individuals change their behavior, and surveillance mechanisms for identifying problems. They remark that, because the American Medical Association encourages it and the Joint Commission requires it, a process for managing disruptive behaviors has been established in most hospitals, but with variable quality and enforcement. They note that a code of conduct from which some are exempt is useless. As long as the faculty member who brings in the grant dollars or the surgeon with the largest volume is excused from responsibility for his or her actions, no code of conduct will have much effect on individual behavior. The importance of a prompt, predictable, and appropriate response to an alleged violation cannot be overemphasized, the authors say.

Dr. Leape and colleagues point out that creating a culture of respect requires action on many fronts: modeling respectful conduct; educating staff on appropriate behavior; conducting routine evaluation of professional behavior as part of an annual performance evaluation; providing counseling and training when needed; learning to work in teams; and supporting front-line changes in daily routines that increase the sense of fairness, collaboration, and individual responsibility.

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